WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

CARBON 14 UREA BREATH TEST REQUISITION
FOR DETECTION OF H.PYLORI BACTERIA
Fax Requests to:
Phone: (519) 254-1727 Fax: (519) 255-2125

INCOMPLETE REQUESTS WILL BE RETURNED—Resulting in Delay or Cancellation of the Procedure.

Patient Information (Please Print)

Name: _____ Date of Birth (MM/DD/YYYY): _____

Sex: ☐ M ☐ F Address: _____ WSIB: _____

Patient's Weight: _____ lbs _____ Kgs Patient's Height: _____ ft _____ in

Health Card #: _____ Version _____ Patient arriving from external healthcare facility: ☐ Y ☐ N

Primary Contact # : _____ Secondary # :_____

PHYSICIAN OFFICE TO COMPLETE:

Diagnosis: _____

Has patient been off ALL antibiotics for the last 31 days? ☐ Y ☐ N

Has the patient taken any Bismuth (Pepto Bismol) in the last 31 days? ☐ Y ☐ N Date Stopped (MM/DD/YYYY):_____

Has the patient taken any of the medications _**listed below**_ in the last 14 days? Please check below:

Brand Name	Generic Name
☐ Losec	☐ Omeprazole
☐ Prevacid	☐ Lansoprazole
☐ Pantoloc or Tecta	☐ Pantoprazole
☐ Nexium	☐ Esomeprazole Magnesium
☐ Pariet	☐ Rabeprazole
☐ Dexilant	☐ Deslansoprazole
☐ Vimovo (naproxen/esomeprazole/magnesium)	☐ Vimovo
☐ Sulcrate	☐ Sulcrafate

NOTE: When you stop taking any of the above medications, **you are allowed to take the following medications instead**:
H2 Blockers (Tagamet, Zantac) Diovol, Domperidone, Axid, Gaviscon, Pepcid, Rolaids, Maalox, Tums, Mylanta, Gelusil or Famotidine.

PATIENT PREPARATIONS AND DIRECTIONS:

- Do not have anything to eat or drink for 6 hours before the test (this includes no food, candy, gum, water or any medication) until after the test is complete.

- You must be able to swallow a whole capsule - (the capsule is made of gelatin, sugar and starch. The gelatin is bovine based and contains NO soya or wheat).

- Bring a current list of your medications with you to the appointment.

- If you are unable to attend your appointment please notify us as soon as possible at 519 254-1727.

Print Referring Physician: _____ Fax Number:_____

Referring Physician Signature: _____

Physicians who require copy of report: _____

PLEASE PROVIDE COPY OF THIS REQUEST TO PATIENT FOR INSTRUCTIONS

APPOINTMENT DATE AND TIME:

DATE (mm/dd/yyyy):_____ TIME:_____ CAMPUS:_____